ANAC Comments to Office of National AIDS Policy
National HIV AIDS Strategy
May 22, 2015

The continuation of the Ryan White program and the full implementation of the Affordable Care Act are the cornerstones of reaching the goals of the National HIV AIDS Strategy. Having a well-prepared, highly skilled and committed interdisciplinary HIV workforce is critical to continuing the progress of the strategy and in achieving the vision of the strategy: *…rare new HIV infections and when they do occur every person will have unfettered access to high quality life extending care, free from stigma and discrimination.*

Interprofessional approaches to primary care and HIV care will remain critical to HIV prevention, wellness promotion and engagement and retention in care. Registered Nurses and Nurse Practioners (NPs) can play a key role in addressing workforce shortages in primary care, HIV biomedical prevention & specialized HIV care. This includes Ryan White funded programs and other sources of health care. Studies show that NPs can manage 80-90% of care provided by primary care physicians. Other evidence shows that primary care outcomes, disease-specific measures, reduction of symptoms, mortality, hospitalization and patient satisfaction, are comparable between patients served by NPs and patients served by physicians. (http://kff.org/medicaid/issue-brief/tapping-nurse-practitioners-to-meet-rising-demand-for-primary-care). In response, the ACA has invested in nursing education and NP preparation. However, since RN and NP practice is regulated by state licensure laws and policy on scope of practice and prescriptive authority, the impact of these advances on public health and HIV care is not uniform across the country. The number one recommendation of the IOM Report *Future of Nursing* was to remove scope of practice barriers and 19 states and DC have done so already and more are in progress. (http://www.iom.edu/Reports/2010/The-Future-of-Nursing-Leading-Change-Advancing-Health.aspx). This will help to expand the HIV workforce.

As a compliment to the recognition of the critical expanded role of nurses, a focus and expansion of federally designated Health Professional Service Areas (HPSA) could contribute to an improved HIV workforce. This HPSA designation allows for to loan repayment in exchange for serving in primary care settings in medically underserved communities. This reciprocal arrangement applies to Nurse Practioners who serve in underserved communities. It could be a mechanism for encouraging new clinicians, including minority students to consider HIV NP programs as a career path.

A continued and expanded investment in HIV specific clinical training programs will be also necessary. We highlight the HRSA/HAB/AETC funded *Expanding HIV Training into Graduate/Health Profession Medical Education* program (http://aidsetc.org/special-initiatives/health-professions). It supports existing accredited primary care residency, graduate nursing, and physician assistant programs to include an HIV focus for medical residents, nurse practitioner students, and physician assistant students in

HIV/AIDS care and treatment. ANAC members lead the AETC funded programs at 4 Schools of Nursing that produce highly skilled & committed Nurse Practioners to work in HIV care. We need more of these programs.

We also highlight the value of the AETC program in targeted and flexible training of the HIV workforce and in training primary care providers about HIV and co-morbidities. AETCs should have the ability to respond to emerging trends and hot spots. The flexibility and mobility of local AETCs in training the local healthcare workforce responding to the HIV outbreak in rural Indiana is an example of the need for a nimble local response within a standardized national structure. Ensuring this balance is important. Emerging technologies such as tele-health and other technology based expanders of the clinical workforce must be encouraged. The expanded use of AETC trained RNs and NPs in medically underserved areas using appropriate technologies can be part of a future effective HIV workforce.

Another consideration in the HIV healthcare workforce is the importance of peers/community health workers (CHWs) and the benefits of a better integration of peers/community workers with the clinical workforce. The critical role of peers in linkage and supporting engagement and retention can be enhanced through better and re-imagined partnerships between CBOs and clinical settings. Designated clinical team members such as RNs or social workers should be educators, mentors and connectors between peers/CBOs and the clinical team, to facilitate the full & effective role of peers/CHWs. The Black AIDS Institute workforce study & report from 2014 identified gaps and the need for effective and ongoing trainings. Competency assurances and perhaps credentialing of CHWs as is the practice in other disease management community strategies (e.g. diabetes) may lead to better accountability and payer reimbursements. In pursuing this strategy, some states place CHWs under the authority of their nursing practice act and require oversight by a RN, but this may not be a fully replicable strategy for HIV peers/CHWs. The critical contributions of peers with incarceration/SA/MH histories should not be jeopardized and improvements in any such state level restrictions will be required.

There is a need for better integration between Prevention and Care & Treatment programs and funding streams. This need has become particularly apparent with PrEP programs. The expertise and infrastructure developed through the Ryan White programs must be better coordinated with CDC and other prevention programs. Funding for PrEP services for uninsured and underinsured people at risk for HIV must be more available. As people at risk seek PrEP, we are seeing some test positive at screening. Seamless transition to care is essential. Funder incentives for co-funded positions and co-located programs are a place to start. Expanded prescriber practice authority for NPs and the deployment of RNs who practice to the full extent of their license, including operating under routine standing orders are workforce strategies that will remove staffing problems/prescriber shortages as barriers to broader PrEP implementation (http://www.nursesinaidscarejournal.org/article/S1055-3290(15)00047-3/abstract).

Finally, evidence based approaches to prevention and care must drive policy decisions. Two areas that resonate strongly with ANAC members and are on our national policy priority agenda are the lifting of the ban on federal funding for Syringe Exchange Programs (SEP) and an end to unfair and unjust HIV exposure/transmission criminalization laws, policies and practices.

It is the position of the Association of Nurses in AIDS Care that syringe exchange programs should be part of a comprehensive strategy for the treatment of substance use, including drug treatment services,

mental health counseling, social support services, harm reduction counseling, and competent primary health care, by providers who are knowledgeable about drug use, addiction, and prevention of bloodborne disease. Federal funds should be released to support the development, implementation, and continued capabilities of syringe exchange programs around the country.

It is also the position of ANAC that HIV criminalization laws and policies promote discrimination, enhance stigma and must be reformed. We have called for the reform of all local, state and federal policies, laws, regulations, and statutes that single out HIV infection or any other communicable disease and that include inappropriate or enhanced penalties for alleged nondisclosure, exposure, and transmission.

The Association of Nurses in AIDS Care supports the goals and vision of the National HIV AIDS Strategy. Our work, our members focus and our national policy agenda reflects this. http://www.nursesinaidscare.org/files/public/ANAC_PolicyPriorities_4252014.pdf. The following recommendations are not all inclusive and we also endorse the recommendations of coalitions and groups that we are active members in such as the Heath Care Access Group of FAPP and others. The following recommendations are mostly specific to workforce development, a critical perspective of ANAC.

Recommendations:

- Encourage HIV care and HIV prevention and primary care settings where RNs and Nurse Practioners practice to the full extent of their license and training.
- Encourage robust interprofessional teams for HIV prevention and care services, including teams led by RNs and NPs.
- Support full practice authority for Nurse Practioners and equitable Medicaid/Medicare/Medicaid HMO reimbursement rates
- Expand the federally designated Health Professional Service Areas (HPSA) to focus on underserved areas of high HIV need to contribute to an improved HIV workforce.
- Expand the HRSA/HAB funded “Expanding HIV Training into Graduate/Health Profession Medical Education” program
- Continue support for a flexible and accountable AIDS Education and Training Center program to improve and expand the HIV workforce. .
- Continue to recognize the value of peers/community health workers and encourage better integration of peers/community workers with the HIV clinical workforce.
- Devise mechanisms and incentives for better integration between Prevention and Care & Treatment programs, particularly around PrEP programs implementation and scale-up.
- Funding for PrEP services, (including support for nurses as PrEP providers) for uninsured and underinsured people at risk for HIV must be more available and equitably distributed.
- Continue to promote education and understanding of the negative clinical and public health consequences of current HIV criminalization statutes, arrests, and prosecutions, and their contribution to HIV-related stigma and discrimination
- Continue to emphasize that evidence based approaches to prevention and care must drive policy decisions, such as the removal of the ban on federal funds for syringe exchange programs.